MEDICARE ELIGIBLE HEALTH PLAN (MEHP)

Medical & Prescription Drug Enrollment Form for the

KENTUCKY TEACHERS' RETIREMENT SYSTEM (KTRS)

479 Versailles Road, Frankfort, KY 40601
Phone: (502)848-8500 or 1-800-618-1687 FAX: (502)573-0199

KTRS USE ONLY

_____
Retirement Date

_____
Effective Date

Reason for Application			
☐ Turning 65	☐ Qualifying Event	☐ Open Enrollment	☐ New Retiree

ENROLLMENT TYPE: (for KTRS MEHP only) Select ONE		
☐ Retiree Only	☐ Retiree & Spouse	☐ Spouse Only

RETIREE ENROLLMENT – Complete if enrolling in the KTRS MEHP

Retiree Name	**Retiree** Social Security/Member ID
Date of Birth	Gender: ☐ Male ☐ Female

☐ I **waive** coverage through the KTRS MEHP.

SPOUSE ENROLLMENT – Complete if enrolling in the KTRS MEHP

Spouse Name	**Spouse** Social Security Number	Date of Birth
Retiree Social Security/Member ID	Gender: ☐ Male ☐ Female	

☐ I **waive** coverage through the KTRS MEHP. I understand by waiving this coverage, I will not be permitted to enroll in the future unless I experience a valid KTRS qualifying event.

If proof of your Medicare Part B coverage is not provided to this office before the MEHP enrollment date, you <u>will not</u> be enrolled in coverage through KTRS. Also, now or in the future, if you are enrolled in another Medicare Advantage plan, another Medicare Part D prescription drug plan, or your Medicare Part B coverage terminates, your KTRS MEHP will be terminated. Upon termination of the MEHP, if you are the spouse of a KTRS retiree, you will not be eligible for future reenrollment unless you experience a valid KTRS qualifying event. For KTRS retirees, changes after the effective date of your insurance may only be made during Open Enrollment or within 30 days of a qualifying event. Obtaining Medicare Part B is considered a qualifying event for KTRS retirees only; but you will only have 30 days from the event date to enroll.

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~ CONTINUED ON REVERSE SIDE ~
WHICH MUST BE COMPLETED IN ORDER TO VALIDATE YOUR

Use your Medicare card to complete this form and return it to KTRS to enroll in the MEHP. If you have applied for Medicare, but have not received your card, you must contact your local Social Security office to request you Medicare number and effective dates of Medicare Parts A and B. Then, upon receiving your Medicare card, you must forward a copy to KTRS.

DEMOGRAPHIC INFORMATION		
Mailing Address		
City	**State**	**ZIP**
PERMANENT Street Address – P.O. Box NOT Allowed		
City	**State**	**Zip**
Email Address	**Home Phone Number**	**Cell Phone Number**

RETIREE INFORMATION – if enrolling in the KTRS MEHP			
RETIREE'S Name	**Social Security Number**	**Married** ☐**YES** ☐**NO**	**Date of Birth**
Medicare Claim Number	**Hospital (Part A) Effective Date**	***Medical (Part B) Effective Date**	
Do you have End Stage Renal Disease (ESRD)? ☐ **YES** ☐ **NO**			

SPOUSE INFORMATION – if enrolling in the KTRS MEHP			
SPOUSE'S Name	**Social Security Number**	**Married** ☐**YES** ☐**NO**	**Date of Birth**
Medicare Claim Number	***Hospital (Part A) Effective Date**	***Medical (Part B) Effective Date**	
Do you have End Stage Renal Disease (ESRD)? ☐ **YES** ☐ **NO**			

By signing below, I confirm I have read and understand all the enclosed documents/materials pertaining to the KTRS MEHP coverage. I also understand that if Medicare indicates I have gone 63 or more days in a row without creditable prescription drug coverage I may receive a form asking about prior drug coverage. If I don't complete the form I may be required to pay a monthly premium penalty to KTRS.

RETIREE'S SIGNATURE _____ **DATE** _____, 20 _____

SPOUSE'S SIGNATURE
(If enrolling in coverage) _____ **DATE** _____, 20 _____

***REQUIRED IN ORDER TO BE ELIGIBLE FOR ENROLLMENT IN THE KTRS MEHP.**